

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Boulevard Temple Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  2567 West Grand Boulevard Detroit, MI 48208	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15194</p> <p>Based on observation, interview, and record review the facility failed to provide a homelike environment for one resident (R74) of eight residents reviewed for comfortable, homelike environments.</p> <p>Findings include:</p> <p>Review of the Admission Face Sheet documented R74 was admitted to the facility on [DATE], with diagnoses that included: osteomyelitis, hypertension, amputation of left lower limb and diabetes mellitus. According to the minimum Data Set (MDS) dated [DATE], R74 had a BIMS (Brief Interview for Mental Status) of 15 indicating intact cognition and required one-person physical assist to perform Activities of daily living (ADL's).</p> <p>On 4/16/24 at 10:30 A.M. and 4/17/24 at 9:00 A.M., during an observation of resident 74's room, the ceiling above the television and hand sink was observed with a gaping hole (approximately 4 x 5 inches wide) with surrounding broken plaster. On the opposite side of the room underneath the window another hole was observed. Two large cans were placed close to each area where the holes were located. R74 was asked about the care and what happened to the ceiling? R74 stated, The holes had been in the ceiling for about two months and staff had brought the two cans to catch the water that entered the holes and cracked plaster. R74 indicated after staff left the cans, no one returned to repair the ceiling and staff acted as though they did not see the cans.</p> <p>During observation of the bathroom it was noted that the cove base was detached from the wall approximately 1/3 the perimeter of the room.</p> <p>On 4/17/24 at 11:23 A.M., during interview and observation of R74's room Maintenance Director (MD) B stated, there was no active leaks in the resident's room. MD B was unable to provide any reason why the cans were left in the room. MD B said daily rounds were done on the units but the rooms with the holes and crumbling plaster had not been identified. MD B explained the facility used TEL's (computerized system for entering repair requests.) MD B was asked to provide any requisitions or orders for R74's needed room repairs. MD B reported, I am not sure if there is anything in the system.</p> <p>In a subsequent interview at 11:40 A.M., MD B acknowledged he recently had been hired at the facility and was not aware of the concerns that had been identified. A policy was requested during the interview and provided on 4/18/24.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/18/24 at 3:00 P.M. review of the facility's policy entitled Resident's Personal Property, dated 9/22/23, did not specifically address homelike environment of resident's rooms in the facility.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 22349</p> <p>Based on observation, interview, and record review, the facility failed to consistently implement interventions (a properly functioning specialty mattress) for one (R57) of seven residents reviewed for pressure ulcer care when R57's specialty mattress resulting in the potential for continued impaired skin integrity.</p> <p>Findings include:</p> <p>On 4/16/24 at 1:15 PM R57 was observed laying in bed. An Alternating Pressure Relief machine was secured on the foot board of the resident's bed with cords connected to the mattress lying on the resident's bed. There were no lights on the machine's display panel and the mattress was deflated and flat even though it was plugged into the electrical socket. The resident appeared to be lying flat on the metal bed frame. When R57 was asked about his mattress he said, Yeah, they know its not working. It's been like this for a couple days now. They put it in TELS or something like that. I'm supposed to get a new one today.</p> <p>On 4/17/24 at 11:25 AM R57 was observed laying on his bed. The Alternating Pressure Relief Machine was still not functioning, and the resident was laying on a deflated, flat mattress. When R57 was asked about the mattress not being replaced yesterday the resident replied, I don't know. Maybe I'll get it today.</p> <p>According to R57's Electronic Health Record (EHR) the resident had admitted to the facility with three stage 4 pressure ulcers (Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). The physician ordered R57 to have an 'alternating pressure relief mattress to his bed on 5/23/23. A review of the resident's Medication Administration Record (MAR) revealed the following order, 'check the Alternating Pressure Relief mattress to bed every shift for wound care' per shift. A review of the MAR from 4/1/24-4/17/24 revealed that nursing staff had documented R57's Alternating Pressure Relief mattress was in use. A care plan for 'actual skin breakdown/pressure injury' initiated the following intervention on 8/24/23; Pressure Reduction mattress to bed or specialty bed. R57's Minimum Data Set (MDS), dated [DATE], indicated that R57 had fully intact cognition and was his own responsible party. A wound care note dated 4/11/24 indicated that R57 currently had two pressure ulcers both at a stage 4 and were stable or improving.</p> <p>On 4/17/24 at 11:30 AM during interview with Nurse Manager, Registered Nurse (RN) G was unaware that R57's mattress was not functioning properly. RN G went to R57's room and acknowledged that the Alternating Pressure Relief mattress was not working properly. RN G said the mattress was being rented from an outside company and he would contact them immediately for a replacement. RN G said, I'm glad you noticed this because he (R57) needs this for his pressure ulcers. He (R57) has to have this mattress because he is not good with turning and repositioning himself.</p> <p>On 4/18/24 at 11:10 AM wound care nurse, Licensed Practical Nurse (LPN) H said had completed R57's wound care on both 4/16/24 and 4/17/24 and had not noticed that the mattress was not functioning properly.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A policy/protocol related to pressure ulcers and information regarding the Alternating Pressure Relief mattress was requested via email and verbally but not provided prior to the survey exit conference.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>22349</p> <p>Based on observation, interview, and record review the facility failed to ensure one (R2) of five residents reviewed for limited range of motion received appropriate services and equipment to maintain or improve mobility.</p> <p>Findings include:</p> <p>R2</p> <p>On 4/16/24 at 1:25 PM, R2 was observed in bed with bilateral upper arm contractures (tightening of the muscles, tendons, skin, and nearby tissue that causes the joints to shorten and become stiff) at both elbows and right wrist joint. No splints were observed. R2 was asked about the arm contractures and replied, I've been like this since I got here. I did have splints, but they lost them a while back and are supposed to get me new ones. I haven't had any therapy for a while. I don't know when I had it last. The resident denied pain or discomfort at this time.</p> <p>On 4/17/24 at 10:47 AM, R2 was in bed with both arms contracted at the elbow and right wrist. No splints were observed. R2 reported that therapy had been in yesterday and were ordering new splints. No therapy had been performed on the resident. The resident denied having any pain or discomfort at this time.</p> <p>A review of R2's Electronic Health Record (EHR) revealed the resident had admitted to the facility in 2017 with multiple diagnoses that included quadriplegia and contractures of all four extremities. On 1/30/24 the physician ordered the resident to have a therapy evaluation and treatment. According to the Occupational Therapy Evaluation and Plan of treatment dated 1/30/24; The patient stated that he would like a splint for his right wrist and fingers to alleviate further contracture and discomfort. Short-Term Goal: Therapist will fit patient with appropriate splint and then monitor results to check for pain, skin breakdown, or other adverse effects. There was no documentation, orders, or plan of care to support R2 had received any splints or monitoring.</p> <p>On 4/16/24 an Occupational Therapy Evaluation and Plan of Treatment included the following plan: Therapist will fit patient with appropriate splints for BUE (bilateral upper extremities) at elbows and right wrist. Patient does not have appropriate splints. A Therapy to Restorative Program Plan dated 4/16/24 detailed passive range of motion exercises to be performed on R2's lower extremities 3-5 times a week for 12 weeks.</p> <p>On 4/17/24 at 11:08 AM nurse manager, Registered Nurse (RN) G was asked to review if R2 had received restorative therapy or splints since 1/30/24. RN G acknowledged that there was no documentation to support R2 had received splints or restorative therapy from 1/30/24.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/17/24 at 12:57 AM Occupational Therapist (OT) I was asked about R2's therapy evaluation from 1/30/24. OT I acknowledged that R2 had not received any splints or restorative therapy from 1/30/24 -4/16/24. OT I said, The resident would benefit from splinting and therapy. We are waiting on authorization from the insurance company to start therapy. OT I was asked if R2 was able to receive restorative therapy without insurance authorization. OT I confirmed that R2 was a candidate for restorative therapy and could not explain why the resident had not received it (restorative therapy) previously.</p> <p>On 4/17/24 at approximately 1:00 PM, Physical Therapist and Therapy Director (PT) J was asked about R2's splints and restorative therapy. PT J could not explain why R2 did not receive splints for his bilateral upper extremities as recommended on the Occupational Therapy Evaluation and Plan of treatment on 1/30/24.</p>

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964</b></p> <p>Based on interview and record review, the facility failed to facilitate a psychiatric evaluation as prescribed for one (R11) of five sampled residents reviewed for unnecessary medications, resulting in the potential for psychosocial disorders to go unaddressed and to exacerbate.</p> <p>Findings include:</p> <p>Record review of the Electronic Medical Record revealed R11 admitted to facility on 10/27/2023 with pertinent diagnosis of unspecified dementia. According to the Minimum Data Set (MDS) dated [DATE], R11 had severe cognitive impairment with a Brief Interview of Mental Status (BIMS) of 3/15.</p> <p>On 12/14/2023 a physician order was written for Escitalopram Oxalate Tablet 10 MG was ordered Give 1 tablet by mouth one time a day for Dementia with Behavior issues/Depression.</p> <p>On 12/21/2023 a physician order was written for Psych consult Dx: evaluation of behaviors and medication.</p> <p>Review of the pharmacist consultation report dated 3/7/2024 revealed R11 had received an antidepressant, Escitalopram 10 mg q day (everyday) for dementia with behaviors- a clear indication for use and history of gradual dose reduction (GDR) were not found in the medical record. Recommendation: Please document the indication for use of this-antidepressant, the outcome of any previous attempts at GDR, and the expected duration of therapy. Please assess if a GDR is appropriate or document a contraindication to GDR.</p> <p>Physician response Continue med psych to follow dated 3/8/24.</p> <p>Record review did not reveal a psychological evaluation.</p> <p>On 4/17/2024 at 3:14 PM the Nursing Home Administrator (NHA) was interviewed and said psychiatric services were ordered but social work did not set up services so R11 has not been seen by psychiatric services. The NHA agreed R11 should have psychiatric services to monitor medications and behaviors as ordered by the attending physician.</p> <p>On 4/17/2024 at 3:28 PM Social Worker (SW) A was interviewed and agreed that psychiatric services were ordered for R11, but services were not set up and it is the responsibility of the social worker to arrange psychiatric services.</p> <p>Review of the facility policy titled Social Services last revised 9/7/2023 revealed in part .Situations in which the facility should provide social services or obtain needed services from outside entities include, but are not limited to the following: Expressions or indications of distress that effect the guest's/resident's mental and psychosocial well-being, resulting from mental or physical, chronic or acute disease states or past or present trauma that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>15194</p> <p>Based on observation, interview, and record review the facility failed to store delivered food stock properly, resulting in a potential for contamination and deterioration of food products.</p> <p>Findings include:</p> <p>On 4/16/2024 at 9:26 A.M. during an observation of the kitchen, delivered food stock was observed stored on the floor outside of the walk-in refrigerator. At 10:10 A.M. Approximately 15-20 cases of assorted refrigerated and dry goods were stacked on the floor waiting to be stored. Dietary Manager E who was present and cleaning the walk-in refrigerator was queried concerning the delivery days for food stock and indicated Tuesday and Thursday.</p> <p>On 4/18/2024 at approximately 9:00 A.M. during an observation of the facility's dumpster area, food stock was delivered into the kitchen and placed on the floor. The delivered food items consisted of a combination of 15-20 cases of food items that required refrigeration and canned food products.</p> <p>At 11:20 A.M. the delivered food stock was observed in the same place without being stored off the floor or placed on a Dollie (device used to prevent items from sitting directly on the floor).</p> <p>At 11:46 A.M. During an interview with Dietary Manager E concerning the length of time the delivered food stock was left sitting on the floor without refrigeration, the manager reported all the employees were serving lunch and there was no available employee to store the food in the refrigerator/Freezer or dry storage.</p> <p>Dietary Manager E was asked, why the delivered food was stored on the floor without a Dollie and/or pallet to prevent contamination or the entry of pests? During the observation the delivery company was observed delivering items to another department using a pallet. The manager explained the department did not have a pallet or Dollie for storing delivered food stock and the vendor had always stored the food stock in the same area until it could be put away by the staff.</p> <p>According to 2013 Food Code, Section 3-305.11 Food Storage: Food shall be protected from contamination by storing the food: 1). In a clean, dry location; 2). Where it is not exposed to splash, dust, or other contamination; and 3). At least 15 centimeter (cm) (6 inches) above the floor.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 22349</p> <p>Based on observation, interview, and record review, the facility failed to ensure Infection Control protocols were followed during care for two residents (R58 and R91) of five reviewed for Infection Control when appropriate protective personal equipment (PPEs) was not applied during direct care. R58 was positive for Covid-19 and R91 was prescribed to have Enhanced Barrier Precautions (EBP).</p> <p>Findings include:</p> <p>According to the facility's policy last revised on 3/26/24, EBP is used to prevent the transmission of CDC targeted multidrug-resistant organisms (MDROs). EBP is indicated for residents with any of the following; 1) infection of colonization with CDC-targeted MDRO or 2) a wound or indwelling medical device even if the resident is not known to be infected or colonized with a MDR) and should remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at higher risk.</p> <p>A. Health care personnel caring for resident on EBP should wear gloves and gowns during high-contact resident care. Examples of high contact resident care activities requiring gown and glove use: .device care or use of . feeding tube.</p> <p>R91</p> <p>On 4/16/24 at 10:14 AM R91's doorway had signage indicating the resident was in Enhanced Barrier Precautions. There was a PPE cart outside the doorway that contained appropriate PPE. Licensed Practical Nurse (LPN) M was observed providing care to R91's feeding tube (soft flexible tube surgically inserted through the abdomen wall into the stomach to deliver nutrition, hydration, and medication). LPN M had a surgical mask and gloves on, but no gown. Upon inquiry, LPN M acknowledged that R91 was in EBP. LPN M said the resident did not have Covid-19 and therefore did not have to wear a gown when providing care. At this time the EBP signage on R91's doorway was reviewed. The sign clearly indicated that gloves and gowns were required during care of any indwelling device including feeding tubes.</p> <p>On 4/16/24 at 1:06 PM, Lab Technician (LT) N was observed drawing blood from R91's arm. LPN N had a surgical mask and gloves on, but no gown. LT N's duffle bag with lab supplies and equipment was resting directly on the resident's bed. Upon inquiry LT N acknowledged that she had observed the EBP signage on R91's doorway. LT N could not say why she did not put a gown on prior to obtaining the blood sample. LT N could not explain why she placed her duffle bag directly on the resident's bed without a barrier in place.</p> <p>According to R91's Electronic Health Record (EHR) the resident admitted to the facility with a history of a MDRO infection after a hip replacement and was treated with intravenous antibiotics. R91 was identified to be at risk for further infection due to having an indwelling urinary catheter, feeding tube, and pressure ulcer wounds. A care plan initiated on 4/11/24 had the following intervention: Enhanced Barrier precautions for urinary catheter, feeding tube, and wounds.</p> <p>Resident 58</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/16/24 at 12:23 PM, Certified Nursing Assistant (CNA) L was observed to go into R58's room carrying the lunch meal tray with a surgical mask, gown, and gloves on. CNA L did not have a N-95 mask, face shield, or goggles on. R58's doorway had signage that clearly indicated he was in Droplet-Based Precautions and required the following PPE; gloves, gowns, N-95 mask, and a face shield or goggles. The PPE cart directly outside R58's doorway was stocked with the appropriate required PPE and had the same signage as R58's doorway. CNA L was asked what type PPE R58 required during care and responded, It's OK to wear this mask (surgical mask) because I was just feeding him. CNA L acknowledged that she was aware R58 was currently positive for Covid-19.</p> <p>A review of R58's EHR revealed the resident had multiple diagnoses that included history of a stroke. R58 had tested positive for Covid-19 and was currently in Droplet-Based Precautions. According to the MDS dated [DATE] R58 was totally dependent on staff for eating.</p> <p>According to the facility's Coronavirus (Covid 19) policy last revised on 2/15/24 in part; Appropriate measures will be utilized for the prevention and control of the Coronavirus (COVID 19) .</p> <p>All recommended COVID-19 PPE should be worn during care of residents under observation or in Transmission Based Precautions, which includes use of a NIOSH approved N95 or higher- level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves and gown.</p> <p>On 4/17/24 at 11:45 AM during an interview with nurse manager Registered Nurse (RN) G the above observations were reviewed. RN G reported being aware that staff had not worn appropriate PPE because the staff had shared the information with him. RN G said, They know better. We have educated them on what PPEs to wear for EBP and Covid every month. The staff are aware that R58 had tested positive for Covid-19 and what Droplet-Based Precautions are. They (the staff) have received one-to-one education. RN G said he would be contacting the lab to review EBP requirements with them.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>15194</p> <p>Based on observation, interview, and record review the facility failed to: maintain cooking equipment and the physical environment in the kitchen in a safe and sanitary manner, repair five rooms and the dining area on the 5th floor, clean the inner spaces of handrails on the fourth and fifth floor and ensure the elevator doors had a smooth, cleanable surface. This deficient practice had the potential to affect all 104 residents that resided within the facility.</p> <p>Findings include:</p> <p>On 4/17/24 at 1:30 P.M. during an observation in the kitchen the cooking equipment (deep fat fryer) Pitco Frialator, the Vulcan stove, South bend double oven, the panel between the fryer and grill and the back splash behind the stove were covered with layers of old, yellow colored grease and ash. The side panel of the stove had pieces of food embedded in the glue-like grease mixture that could not be removed even after observing staff cleaning the equipment daily.</p> <p>The walls and ceilings throughout the kitchen, dish room and preparation areas were observed with chipped paint, crumbling, missing plaster, large dark-colored, yellow stains, and holes from previous fixtures and/or pipes that had been removed.</p> <p>The middle support column near the old tray line area had several detached stainless-steel protectors/shields that were detached from the column and posed an injury risk to the employees. The brick cove base at the bottom of the column wasn't intact, there was exposed cement residue and pieces of cracked, missing tile visible.</p> <p>The air vents in the dish room and kitchen area were heavily soiled with grease, lint, and rust spots from the moisture in the area.</p> <p>Gnats were observed inside the open moist, dustpan hanging on the wall.</p> <p>The grill of the industrial fan was soiled. Visible lint and grease strings were observed.</p> <p>Water in the hand sink in the dish room continuously ran, even when the faucet was positioned in the off position. The Tile and grout in the corner junction of the dish machine was soiled with a dark colored, mold-like substance. The caulking beneath the scrape table and along the sides were cracked allowing accumulation of water and the potential for bacterial growth.</p> <p>Underneath the dirty end of the scrape table approximately 20-30 (3 X 5) floor tiles were broken and loosely fitted within the grout. Standing water could be seen in the cemented loose grout.</p> <p>The drain and floor underneath the three-compartment sink was heavily soiled and needed deep cleaning. The window above the three-compartment sink had missing pieces of tiles.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Boulevard Temple Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  2567 West Grand Boulevard Detroit, MI 48208	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the observations Dietary Manger E was queried about the condition of the cooking equipment and physical environment of the kitchen. The manager stated, four bids had been previously submitted for repairs and painting of the kitchen. There had not been a notification of approval. The manager was asked, how frequently the equipment was cleaned? The manager stated, The employees had a cleaning schedule that was followed but the equipment required deep cleaning and the kitchen was painted seven years ago.</p> <p>On 4/16/24 at 10:30 A. M. on the fifth floor the following rooms: (511, 519, 523, 524, 525) were observed with chipped paint, bubbling plaster, detached cove bases, and stained ceilings. The dining area on the floor had multiple yellow rings exiting the north side of the unit.</p> <p>On the fourth and fifth floor the areas between the wall and handrail were covered with spilled condiments, exposed wire, food crumbs, butter, and dust. This area was observed being used to set up trays and to serve the resident's food.</p> <p>Paint on one of the two doors of the elevator on the North side of the first floor had peeled off. The bare area extended the entire length of the elevator door which was used by the residents, visitors, and staff. The exposed surface was not smooth for adequate cleaning.</p> <p>On 4/18/24 at approximately 1:30 P.M. during the Quality Assurance interview with the Nursing Home Administrator concerning the identified concerns in the kitchen and physical environment he indicated they would be addressed.</p>